



**University of
Zurich**^{UZH}

**Zurich Open Repository and
Archive**

University of Zurich
University Library
Strickhofstrasse 39
CH-8057 Zurich
www.zora.uzh.ch

Year: 2005

Low T3 Syndrome in Head-Injured Patients is Associated with Prolonged Suppression of Markers of Cell-Mediated Immune Response

Hans, Volkmar H ; Lenzlinger, Philipp M ; Joller-Jemelka, Helen I ; Morganti-Kossmann, Maria C ;
Kossmann, Thomas

Abstract: Purpose:: To clarify the association between disturbed thyroid hormone metabolism (low T3 syndrome) and release of cytokines and markers of cell-mediated immune response. Material and Methods:: Concentrations of cytokines as well as of thyroid hormones were determined in 32 patients suffering from severe traumatic brain injury: interleukin-(IL-1, IL-6, IL-10, tumor necrosis factor, transforming growth factor-(TGF-), soluble interleukin-2 receptor (sIL-2R), neopterin, and 2-microglobulin (2m) in serum and cerebrospinal fluid; triiodothyronine (T3), free T3, thyroxine (T4), free T4, thyrotropin, thyroxine-binding globulin, and albumin in serum. Additionally, clinical parameters were assessed: Glasgow Coma Score, CT scan, intracranial pressure, Glasgow Outcome Score, and occurrence of pneumonia. Results:: Among 31 patients with a low T3 syndrome, those with additional low serum T4 levels (n = 13) showed a prolonged suppression of serum 2m, neopterin, and sIL-2R, and a higher secondary increase of serum 2m, neopterin, and TGF-, as well as lower T3 levels (all $p < 0.05$). These patients also had a longer stay in the intensive care unit (34 ± 6 days vs. 22 ± 12 days; $p = 0.008$). Increased levels of 2m correlated with a preceding decrease of thyrotropin (cerebrospinal fluid: $r = -0.53$; $p = 0.004$; serum: $r = -0.41$; $p = 0.029$). Associations of thyroid hormone metabolism with either other cytokines or with clinical parameters were not detected. Conclusion:: These results show that low T3 syndrome is a very common pathophysiological feature after severe traumatic brain injury. The association of a low T3 syndrome in combination with low serum T4 levels, with an altered time course of markers of cell-mediated immunity led the authors to hypothesize that a disturbed thyroid hormone metabolism may be interrelated with a prolonged cellular immune dysfunction after traumatic brain injury

DOI: <https://doi.org/10.1007/s00068-005-2068-y>

Posted at the Zurich Open Repository and Archive, University of Zurich

ZORA URL: <https://doi.org/10.5167/uzh-155979>

Journal Article

Published Version

Originally published at:

Hans, Volkmar H; Lenzlinger, Philipp M; Joller-Jemelka, Helen I; Morganti-Kossmann, Maria C; Kossmann, Thomas (2005). Low T3 Syndrome in Head-Injured Patients is Associated with Prolonged Suppression of Markers of Cell-Mediated Immune Response. *European Journal of Trauma*, 31(4):359-368.

DOI: <https://doi.org/10.1007/s00068-005-2068-y>

Low T_3 Syndrome in Head-Injured Patients is Associated with Prolonged Suppression of Markers of Cell-Mediated Immune Response

Volkmar H. Hans^{1,2*}, Philipp M. Lenzlinger^{2,3*}, Helen I. Joller-Jemelka⁴, Maria C. Morganti-Kossmann^{2,5}, Thomas Kossmann^{3,5}

Abstract

Purpose: To clarify the association between disturbed thyroid hormone metabolism (low T_3 syndrome) and release of cytokines and markers of cell-mediated immune response.

Material and Methods: Concentrations of cytokines as well as of thyroid hormones were determined in 32 patients suffering from severe traumatic brain injury: interleukin-(IL-)1, IL-6, IL-10, tumor necrosis factor, transforming growth factor-(TGF-) β , soluble interleukin-2 receptor (sIL-2R), neopterin, and β_2 -microglobulin (β_2m) in serum and cerebrospinal fluid; triiodothyronine (T_3), free T_3 , thyroxine (T_4), free T_4 , thyrotropin, thyroxine-binding globulin, and albumin in serum. Additionally, clinical parameters were assessed: Glasgow Coma Score, CT scan, intracranial pressure, Glasgow Outcome Score, and occurrence of pneumonia.

Results: Among 31 patients with a low T_3 syndrome, those with additional low serum T_4 levels ($n = 13$) showed a prolonged suppression of serum β_2m , neopterin, and sIL-2R, and a higher secondary increase of serum β_2m , neopterin, and TGF- β , as well as lower T_3 levels (all $p < 0.05$). These patients also had a longer stay in the intensive care unit (34 ± 6 days vs. 22 ± 12 days; $p = 0.008$). Increased levels of β_2m correlated with a preceding decrease of thyrotropin (cerebrospinal fluid:

$r = -0.53$; $p = 0.004$; serum: $r = -0.41$; $p = 0.029$). Associations of thyroid hormone metabolism with either other cytokines or with clinical parameters were not detected.

Conclusion: These results show that low T_3 syndrome is a very common pathophysiological feature after severe traumatic brain injury. The association of a low T_3 syndrome in combination with low serum T_4 levels, with an altered time course of markers of cell-mediated immunity led the authors to hypothesize that a disturbed thyroid hormone metabolism may be interrelated with a prolonged cellular immune dysfunction after traumatic brain injury.

Key Words

Brain injuries · Cytokines · Euthyroid sick syndromes · Human · Immunology · Trauma

Eur J Trauma 2005;31:359–68

DOI 10.1007/s00068-005-2068-y

Introduction

Alterations in thyroid hormone metabolism and regulation occur in virtually all patients admitted to the intensive care unit, irrespective of a preexisting thyroidal dis-

* Both authors contributed equally to the paper,

¹Institute of Neuropathology, Evangelisches Krankenhaus, Bielefeld, Germany,

²Research Division, Department of Surgery, University Hospital, Zurich, Switzerland,

³Division of Trauma Surgery, Department of Surgery, University Hospital, Zurich, Switzerland,

⁴Division of Clinical Immunology, Department of Internal Medicine, University Hospital, Zurich, Switzerland,

⁵Department of Trauma Surgery, The Alfred Hospital & Monash University, Melbourne, VIC, Australia.

Received: June 14, 2005; revision accepted: June 27, 2005.

ease. These alterations are mainly characterized by a decrease in serum triiodothyronine (T₃) levels (low T₃), while an additional drop in serum thyroxine (T₄) may occur in the clinically more severe cases (low T₃-low T₄), which is associated with an increased mortality rate [1, 2]. The reduced T₃ and/or T₄ levels are associated with normal or low serum thyrotropin values. The etiology of this disturbance is only partially understood. Changes within the central nervous system (CNS) as well as in the periphery were charged causal, like decreased production of hypothalamic thyrotropin-releasing hormone, decreased generation of T₃ by liver thyroxin deiodinase type 1, altered serum transport capacity by thyroxin-binding globulin (TBG), or a T₃/T₄ tissue transport defect [1, 2]. This endocrine disturbance has been given different names, such as the “low T₃ syndrome”, “euthyroid sick syndrome”, or “non-thyroidal illness syndrome” and there is still disagreement on the terminology, reflecting the unresolved pathophysiology of these changes and the still open question of a true tissue hypothyroidism [1–3]. In our study, we prefer to use the more descriptive term “low T₃ syndrome”, thus avoiding inferences on function or mechanisms.

Cytokines represent a group of locally and systemically released inflammatory proteins held responsible for changes in the hypothalamic-pituitary-thyroid axis equal to those found in low T₃ syndrome (for review see [4]). The list of factors investigated includes pro-inflammatory (tumor necrosis factor [TNF], interleukin-[IL-]1, IL-6) and anti-inflammatory cytokines (IL-10) as well as markers of mononuclear cell activation (soluble interleukin-2 receptor [sIL-2R]) [4–6]. In particular, serum IL-6 concentrations were shown to correlate with low T₃ levels in clinical studies enrolling patients with a large spectrum of disorders [7–9]. However, this issue is questioned by recent studies in which neutralization of cytokine activity failed to prevent the low T₃ syndrome following lipopolysaccharide challenge [10–12]. Many of the clinical studies are cross-sectional and limited to predefined serum sampling, thus possibly missing time effects, and they exclude the central nervous compartment that is pivotal in the regulation of the hypothalamic-pituitary-thyroid axis. Based on these premises, individuals with severe traumatic brain injury (TBI) represent an interesting subgroup of patients for studying the low T₃ syndrome in humans, since they are usually healthy until the defined beginning of the disease at the time of injury, and since the peripheral as well as the central nervous compartment are accessible. The low T₃ syndrome is a common

Table 1. Epidemiologic and clinical data of 32 patients with severe traumatic brain injury.

Patient #	Sex	Age (years)	GCS ^a	CT ^b	ICP ^c (mmHg)	GOS ^d	Pneumonia ^e
1	Male	21	3	DI IV°	140	1 (5)	
2	Female	59	10	EML	87	1 (7)	
3	Male	42	3	NEML	108	1 (9)	
4	Male	67	5	EML	21	1 (10)	
5	Male	35	8	DI III°	110	1 (10)	
6	Male	23	3	NEML	86	1 (12)	x
7	Male	73	6	DI II°	11	1 (104)	
8	Male	27	3	DI II°	25	3	
9	Male	53	3	DI II°	29	3	x
10	Male	56	5	EML	24	3	
11	Male	22	5	DI II°	19	3	x
12	Male	26	5	DI II°	42	3	
13	Female	51	5	DI II°	35	3	
14	Male	21	3	DI II°	10	4	
15	Male	26	4	DI II°	56	4	x
16	Female	31	5	DI II°	31	4	x ^f
17 ^g	Male	45	6	DI II°	29	4	
18	Male	48	8	DI III°	41	4	
19	Male	17	8	DI II°	19	4	
20	Male	31	11	EML	33	4	x
21	Male	48	12	EML	89	4	
22	Male	18	3	DI II°	34	5	x
23	Male	42	3	DI II°	28	5	x
24	Male	55	5	EML	24	5	
25	Female	17	6	DI II°	25	5	x
26	Male	41	10	DI II°	24	5	x
27	Female	35	11	DI II°	12	5	
28	Female	23	12	DI II°	43	5	
29	Female	25	14	EML	30	5	
30	Male	16	14	EML	28	5	
31	Female	34	14	DI II°	26	5	
32	Male	59	14	DI II°	40	5	x

^a GCS: Glasgow Coma Score [56]

^b CT: classification of computed tomography of the brain at admission [30]: DI II°–IV°: diffuse injury grade II–IV; EML: evacuated mass lesion; NEML: nonevacuated mass lesion

^c ICP: maximal intracranial pressure persisting for > 5 min

^d GOS: Glasgow Outcome Score [31]: 1: dead, 3: severely disabled, 4: moderately disabled, 5: good recovery; numbers in brackets: days of survival

^e Pneumonia: diagnosis was made if the following criteria were met: pulmonary infiltrates; signs of inflammation (fever, increased serum levels of C-reactive protein, leukocytosis); detection of pathogens in tracheal/bronchial material. This was required for antibiotic treatment. Drugs were not administered on a routine prophylactic regimen

^f This patient suffered from *Pseudomonas* sepsis

^g patient without low T₃ syndrome

component of the pathophysiology of severe TBI [13–18], and the release of different cytokines such as IL-6, IL-10, TNF or pleiotropic transforming growth factor-(TGF-) β into serum and cerebrospinal fluid (CSF) has previously been shown in these patients [19–21], suggesting a possible physiological link between these cascades.

In the present study we therefore investigated the interrelation of thyroid hormone levels with cytokine levels in serum and CSF as well as with other clinical data in patients suffering from severe TBI. We have se-

Table 2. List of assays used for analysis of cytokines/leukocyte activation markers in serum and cerebrospinal fluid. (n) gives the number of brain-injured patients in whom the amount of serum and cerebrospinal fluid was sufficient for a determination throughout the study. β 2m: β ₂-microglobulin; IL: interleukin; sIL-2R: soluble interleukin-2 receptor; TGF: transforming growth factor; TNF: tumor necrosis factor.

Parameter (n)	Source	Detection limit
β 2m (30)	Medizintechnik GmbH, Freiburg, Germany	0.11 pg/ml
IL-1 β	R&D Systems, Minneapolis, MN, USA	0.3 pg/ml
sIL-2R (31)	T-Cell Sciences Inc., Cambridge, MA, USA	0.1 U/ml
IL-6 (32)	R&D Systems, Minneapolis, MN, USA	0.35 pg/ml
IL-10 (24)	Biosource, Camarillo, CA, USA	0.2 pg/ml
Neopterin (30)	Ges. für Immunchemie und -biologie mbH, Freiburg, Germany	0.1 ng/ml
TGF- β 1 (19)	Genzyme, Cambridge, MA, USA	50 pg/ml
TNF (30)	NBS Biologicals, Cambs, UK	0.09 pg/ml

lected a group of pro- and anti-inflammatory cytokines, some of which have been investigated in previous studies although using serum samples only [4–6]. Since T-lymphocyte-derived sIL-2R has been shown to correlate with the extent of low T₃ syndrome [5, 22] and due to the fact that thyroid hormones themselves influence cellular immune functions [23, 24], we measured further lymphocyte counts and mononuclear cell activation markers (i.e., neopterin, β ₂-microglobulin [β 2m]). Neopterin is synthesized by stimulated monocytes/macrophages [25], and β 2m is released by activated lymphocytes and neutrophils [26, 27].

Material and Methods

Patients and Sampling of Serum and CSF

In this observational study, 32 patients were enrolled with the primary diagnosis of severe TBI (see Table 1). Exclusion criteria were the following: systemic injuries requiring further treatment, i.e., long-bone or spine fractures, and visceral damage; known or suspected pre-existing thyroid or pituitary/hypothalamic disorders; general medical conditions requiring drugs known to interfere with thyroid hormone metabolism or regulation; steroid treatment. According to a standardized protocol, all patients received indwelling ventricular catheters for the monitoring and treatment of increased intracranial pressure (ICP) [28]. All patients were enterally tube-fed thus avoiding “fasting”, and received low-dose dopamine (3 μ g/kg/min) for renal support. Blood and CSF were taken on admission (day 0) and daily between 07:00 and 09:00 a.m. thereafter. Samples were either processed directly (thyroid parameters) or centrifuged at 170 \times g for 10 min at 4 °C and supernatants were frozen at –80 °C until analyzed. Sample collection was performed up to 3 weeks after trauma or until re-

moval of the intraventricular catheter when ICP remained stable \leq 15 mmHg for 24 h. Glasgow Coma Score (GCS) [29] was documented on the scene. Computed tomography (CT) of the brain was performed at admission and classified according to Marshall et al. [30]. Maximal ICP levels persisting for > 5 min were recorded daily, and pneumonia was diagnosed as described in Table 1. Total lymphocyte counts were assessed daily using an automatized cell counter (Technicon H*1, Bayer

Diagnostics GmbH, Munich, Germany). Time from trauma until discharge from the intensive care unit was recorded, and clinical outcome was assessed at 6 months after injury using the Glasgow Outcome Score (GOS) [31]. The Zurich University Hospital Medical Ethics Board approved the protocol and waived the need for informed consent.

Measurement of Cytokines and Thyroid Hormones

Cytokines and inflammatory mediators as well as thyroid hormones were analyzed using commercially available assays. Thyroid parameters (T₃, T₄, FT₃ [free T₃], FT₄ [free T₄], thyrotropin) were measured by chemiluminescence (ACS:180, Ciba Corning Diagnostics AG, Dietlikon, Switzerland). A radioimmunoassay was used for TBG (CIS bio international, Gif-sur-Yvette, France), and albumin levels were determined by laser photometry (BNA Automat, Behring Werke, Marburg, Germany). Besides neopterin (radioimmunoassay), all cytokines/leukocyte activation markers were measured by ELISA (Table 2). The time course of cytokine concentrations in CSF and serum after TBI has been previously described in detail for IL-6 [20], TGF- β [21], TNF, IL-10 [19], sIL-2R, β 2m, and neopterin [32]. Here, these data were complemented by analyzing peak concentrations and the corresponding days of maximal levels for each patient. Due to limitations in the amounts of CSF obtained, complete analyses could not be performed in all patients.

Data Analysis

Statistical analysis was performed using a commercially available data analysis system (StatView®5.0, SAS Institute Inc., Cary, NC, USA). Due to the organization of the data, serial measurements were analyzed using summary measures, i.e., peak values and time to maximum/

minimum response for thyroid hormones and cytokines [33]. Due to different time periods during which measurements were performed for each patient, an area-under-curve analysis was not applicable. Dichotomized outcome variables were GOS (favorable: GOS 4 or 5, vs. unfavorable: GOS 1–3) and low T₃ syndrome state (low T₃ vs. low T₃-low T₄). Data were analyzed using Fisher's exact test, Mann-Whitney U-test, Wilcoxon signed rank test, Spearman rank correlation and multiple regression as appropriate. For multiple logistic regression, patients were grouped into low- or high-level responders according to their maximum cytokine concentrations being below or above the median value, respectively. Values were log-transformed for multiple stepwise backward regression as appropriate. A significance level for $\alpha < 0.05$ was used throughout all tests. Data are given as mean \pm standard deviation (SD), unless stated otherwise.

Results

Among the 32 patients investigated (37.1 ± 15.8 years; 24 male, eight female), only one showed normal levels for all thyroid parameters besides FT₃ (2.5 pmol/l , normal $\geq 3.5 \text{ pmol/l}$). This individual seemed not to suffer from TBI-associated low T₃ syndrome and was excluded from further analyses in order to obtain a homogeneous study group (low T₃ vs. low T₃-low T₄). All other 31 patients showed T₃ and FT₃ levels below the normal range at any time after TBI (Figure 1). Decreased serum concentrations were observed for T₄ and FT₄ in 13 and 21 individuals, respectively. Elevation of FT₃ concentrations was not observed in the early time period. Patients with low T₃-low T₄ showed lower T₃ concentrations than patients with low T₃ only ($p = 0.005$; Figure 1), while minimal T₃ levels were reached almost simultaneously in both groups. Thyrotropin showed decreased levels in twelve patients, remained normal during the whole study period in 16, and

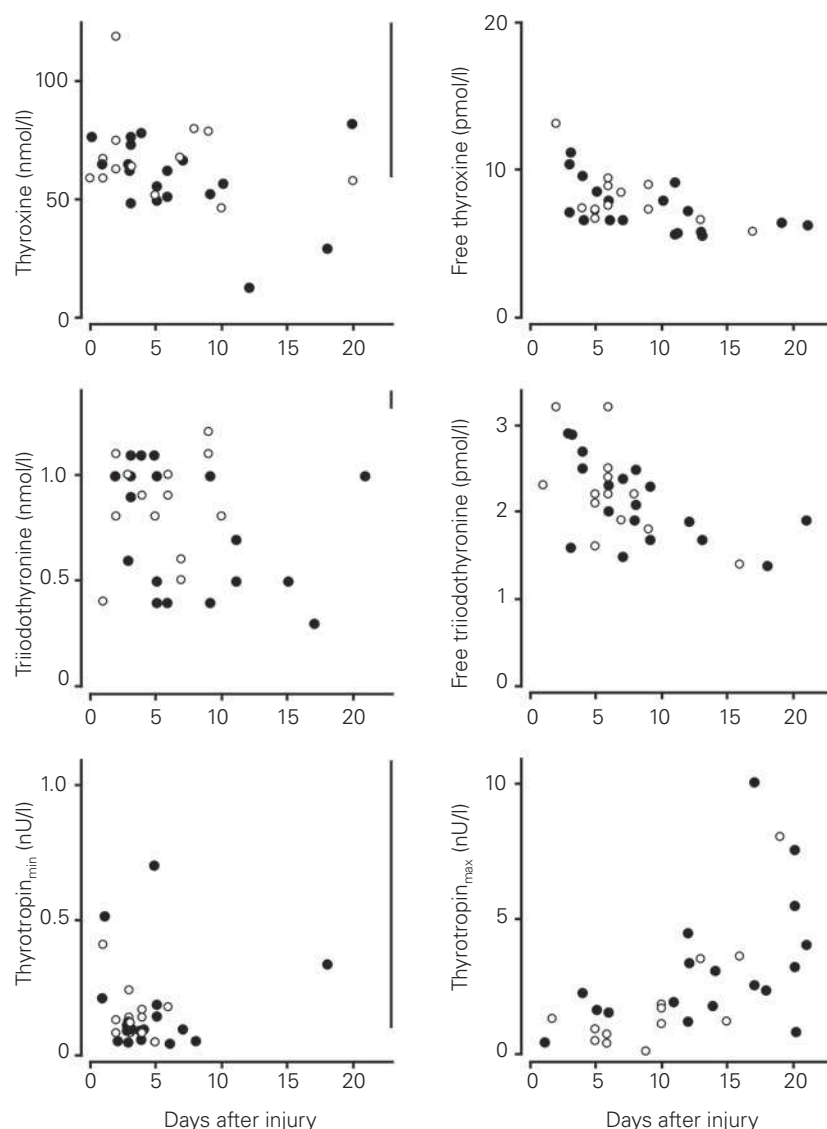
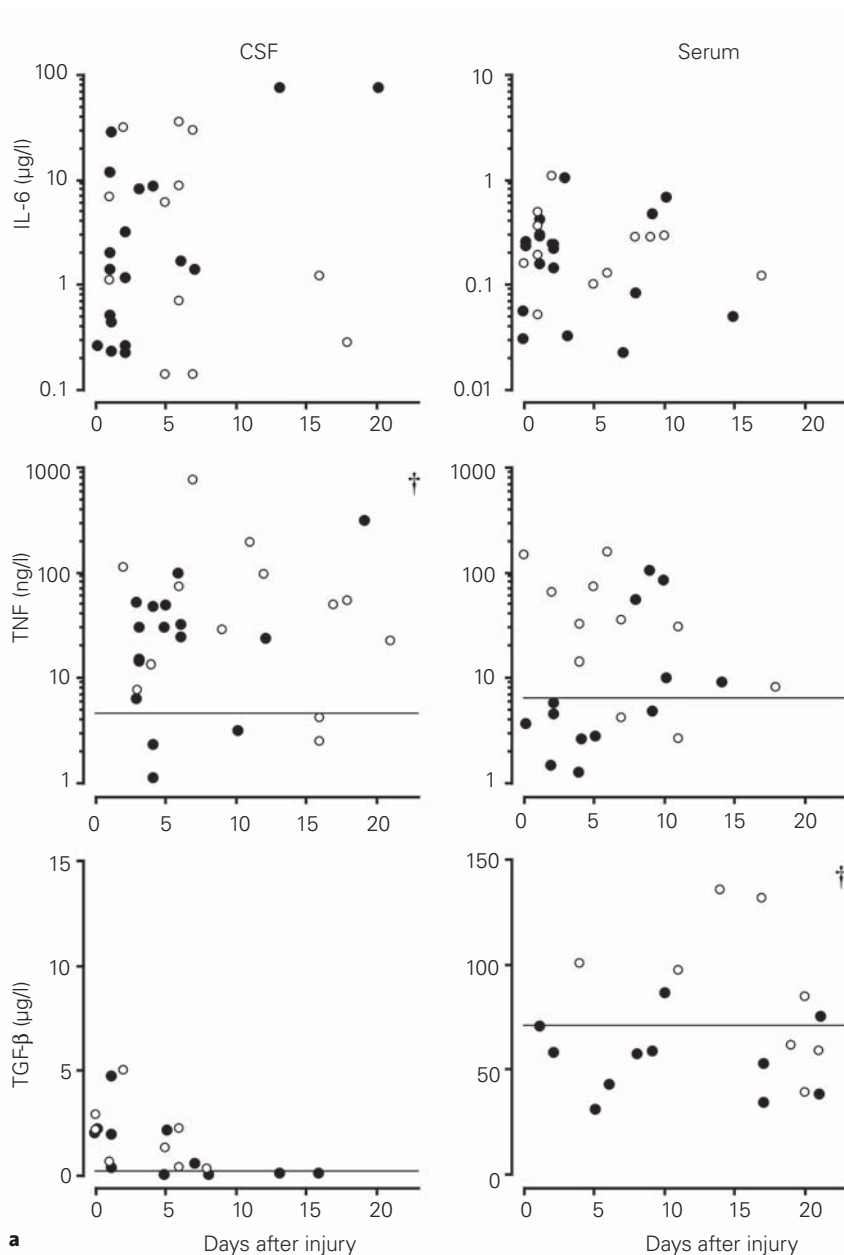


Figure 1. Serum concentrations of thyroid hormones and thyrotropin of 31 patients with low T₃ syndrome up to 3 weeks after traumatic brain injury. Scatter plots show the minimal concentration versus the day of the minimal level of the respective parameter for each patient. For thyrotropin also maximal values after secondary increase are shown (Thyrotropin_{max}). One data point is shown for each patient. Normal ranges are outlined by black bars on the right. Levels below the normal range were found for free triiodothyronine in all patients. A more severe low T₃-low T₄ syndrome was detected in 13 patients. Data are split by clinical outcome: closed circles = favorable, i.e., Glasgow Outcome Score 4/5; open circles = unfavorable, i.e., Glasgow Outcome Score 1–3. No significant differences were found between both groups.

increased later on in six patients. Decreased thyrotropin concentrations were not associated with the lowest T₃ or T₄ levels. Albumin and TBG levels remained within the normal ranges during the whole study period in almost all patients. Lymphocyte counts were below the normal range ($1,500\text{--}4,000/\mu\text{l}$) in all patients investigated with a mean lowest number of $580 \pm 200/\mu\text{l}$ (range $320\text{--}1,140/\mu\text{l}$) and a nadir at day 4.8 ± 3.2 (range 0–11). A favorable



Figures 2a and 2b. Maximal concentrations of a) cytokines (interleukin-[IL]-6, tumor necrosis factor [TNF], transforming growth factor-[TGF]- β) and b) markers of cellular immune activation (β_2 -microglobulin, soluble interleukin-2 receptor [sIL-2R], neopterin) in cerebrospinal fluid (CSF) and serum up to 3 weeks after traumatic brain injury. Scatter plots show the maximal concentration versus the day when the respective parameter reached its maximal level for each patient. One data point is shown for each patient. Lines indicate upper limits of normal ranges. For IL-6, all patients showed increased concentrations at any time. Normal values for this cytokine were below the range depicted in the graphic. Data are divided according to the T_3 state: closed circles = low T_3 ; open circles = low T_3 -low T_4 . Parameters showing significant differences ($p < 0.05$) between these two groups are labeled (†); cf. also the Results section.

Figures 2b. See next page.

outcome was found in 18 out of 31 patients. No correlation was detected between GCS, or GOS, and low T_3 state. However, considering survivors only, patients

with low T_3 -low T_4 remained significantly longer at the intensive care unit (33.8 ± 5.6 days) as compared to those with low T_3 only (22.2 ± 12.4 days; $p = 0.008$). Almost all patients (28/31) suffered from increased ICP, and diagnosis of pneumonia as a typical systemic infectious complication was made in one third (11/31) of the TBI victims (see Table 1). Statistically significant associations were absent among these parameters (i.e., ICP, pneumonia) or CT classification and peak values of thyroid hormones or cytokines.

IL-1 concentrations showed no consistent pattern of increase, neither in serum nor in CSF. Only sporadic peaks were observed, and thus this parameter was excluded from further statistical analyses. According to the time of maximal levels, inflammatory markers could be classified as immediate (IL-10 CSF and serum, IL-6 CSF, and TGF- β CSF), prolonged (TNF CSF and serum, IL-6 serum, sIL-2R CSF, β_2 m CSF, and neopterin CSF), or delayed responders (sIL-2R, β_2 m, neopterin, and TGF- β , all in serum; Figures 2a and 2b). In particular for the last group, the peak levels appeared significantly later than the minimal levels of T_3 , T_4 , or thyrotropin, i.e., the cytokines peaked after the minima of the hormone levels ($p < 0.05$). Similarly, thyrotropin reached its minimal levels before β_2 m, neopterin, and TNF peaked in CSF ($p < 0.05$).

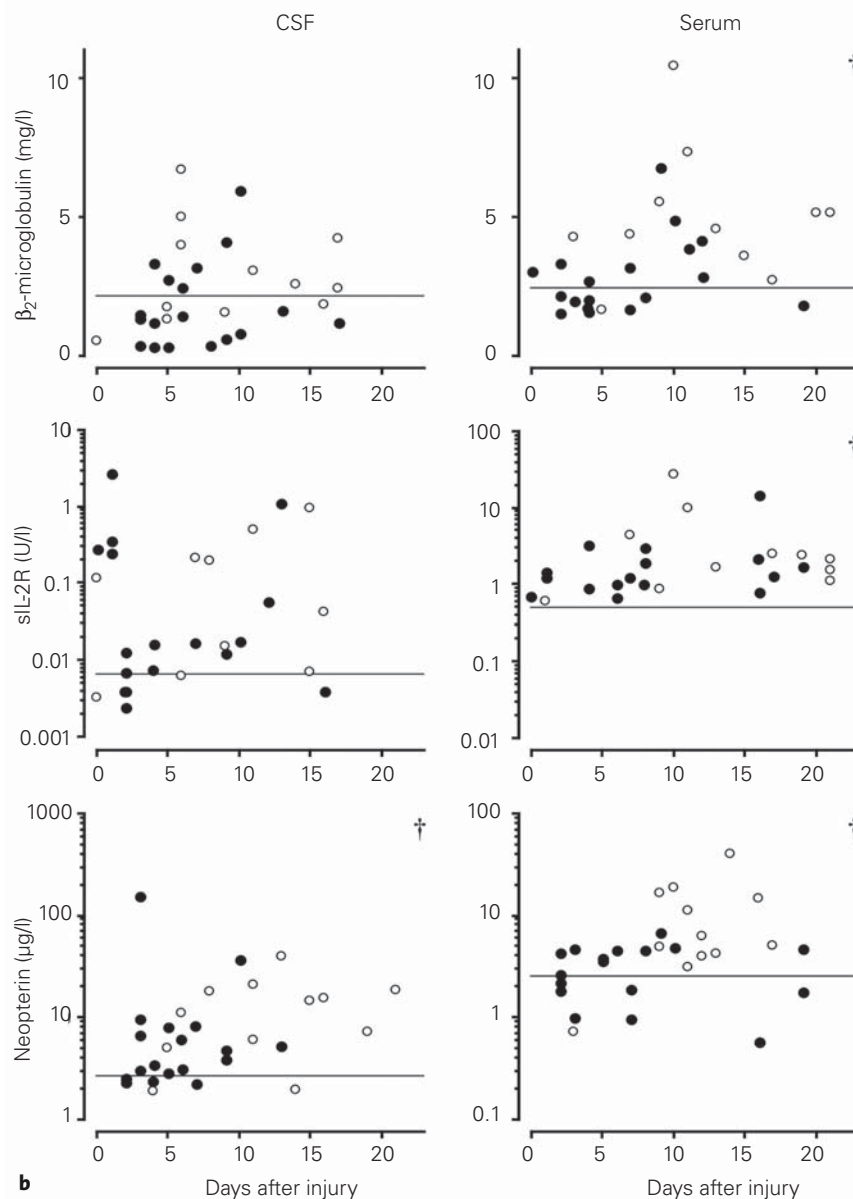
Additionally, we investigated whether a more severe low T_3 syndrome (i.e., low T_3 -low T_4) may be associated with an increased or prolonged release of pro- or anti-inflammatory parameters. Higher serum levels were observed of β_2 m, neopterin, and TGF- β in low T_3 -low T_4 as compared to low T_3 alone ($p = 0.006$, $p = 0.009$, and $p = 0.023$, respectively; Figures 2a and 2b). Maximum levels were

reached significantly later in patients with low T_3 -low T_4 of $\beta 2m$, neopterin, and sIL-2R in serum ($p = 0.019$, $p = 0.015$, and $p = 0.015$, respectively), and of neopterin and TNF in CSF ($p = 0.016$ and $p = 0.038$, respectively).

To investigate the potential role of cytokines in modulating the onset and severity of the low T_3 syndrome, we only used cytokines peaking early after TBI or simultaneously with thyroid parameters for multiple logistic regression. Neither these calculations nor separately performed Fisher's exact test revealed any association of cytokine release with the low T_3 syndrome. The latter tests were performed to increase the chances to detect any differences. Changes in thyrotropin concentrations could not be associated with cytokine levels in the patients investigated (multiple stepwise backward regression). However, increased levels of $\beta 2m$ correlated with a preceding decrease of thyrotropin (CSF: $\rho = -0.528$; $p = 0.004$; serum: $\rho = -0.414$; $p = 0.029$; Spearman rank). Altogether, there was no independent association between any of the cytokine measurements and the measurements of either circulating thyroid hormones or thyrotropin.

Discussion

In this study, we have characterized a group of 32 patients with isolated severe TBI with regard to thyroid hormonal status and to cytokine levels in CSF and in serum from the day of trauma up to 3 weeks post injury. Our data corroborate previous findings, demonstrating altered thyroid hormone metabolism in TBI patients [13, 14, 17, 18]. Only one patient did not present with a low T_3 syndrome. The reason for this single outlier, unfortunately, remains unclear, since none of the clinical and physiological parameters recorded for these patients did explain the absence of an altered thyroid hormonal status in this one patient. Serum T_3 levels were below the normal range in



Figures 2a and 2b. Legend see page 363.

31 patients and an additional decrease of T_4 was observed in 13 of them. Decreased concentrations of thyrotropin were detected during the first week in twelve patients. Since the mechanisms causing these changes are a matter of debate [1, 2, 4], we monitored cytokine concentrations in CSF and in serum of these patients in order to investigate a putative impact of an intrathecal or peripheral inflammatory response on the low T_3 syndrome.

The major finding of our study was a delayed and marked increase of markers of leukocyte activation, mainly $\beta 2m$ and neopterin, but also of sIL-2R and TGF- β . These markers showed a later or more intense

increase in more severely ill patients (i.e., low T₃-low T₄), even though the time point (day post trauma) of minimal T₃ levels did not differ between both groups (low T₃ vs. low T₃-low T₄). Similarly, β 2m showed a stronger increase when thyrotropin was more suppressed at earlier time points.

Head injury is followed by an almost immediate drop of lymphocyte numbers that is accompanied by a deficit in T-cell activation and decreased CD25 expression. These changes seem to persist up to several weeks after TBI [21, 34, 35]. β 2m is a small glycoprotein and elevated levels of the soluble form are thought to reflect the release by activated lymphocytes and neutrophils [26, 27]. Neopterin is synthesized and released exclusively by monocytes/macrophages upon stimulation with interferon-(IFN-) γ and is thus considered an activation marker of T-cells in a number of disorders [25]. IL-2R- α is expressed on T- and B-cells as well as on monocytes/macrophages and is shed in a soluble form from the T-cell membrane upon stimulation. It is not only a sensitive and quantitative marker for mononuclear cell activation but may also inhibit effects of IL-2 by scavenging [22].

In part, the increase of these activation markers may be due to a secondary rise in neutrophil granulocyte counts, whereas monocyte numbers showed no significant changes after TBI [20]. At the same time, T-cell numbers and function remain suppressed for up to 3 weeks after injury [21, 34, 35]. However, elevations of sIL-2R and neopterin, representing a sustained activation of the IFN- γ and TNF pathways, are not necessarily synonymous for an efficient immune response [36]. Although our data indicate a negative correlation between serum T₃ and sIL-2R, similarly to the findings by Boelen et al. [5], we disagree with their conclusion implicating the low T₃ syndrome as the consequence rather than the cause of activation of the cytokine network. Our long-term longitudinal study clearly demonstrated that the increase of activation markers occurred after the drop of thyroid hormones. Therefore, it would be more appropriate to hypothesize that a suppression of T-cells was due to lowered T₃/T₄ levels after TBI. Recently, it has become clear that T₃ exerts pleiotropic effects on the thymus by inducing thymocyte proliferation and release from thymic nurse cells [37]. Strong evidence also exists for a modulation of serum sIL-2R levels by thyroid hormones [23, 24]. An action of thyroid hormones on thymic function in head-injured patients was suggested by the observation that low T₃ levels correlated with decreased thymulin

concentrations [38]. The molecular associations observed in this study together with previous experimental findings may therefore indicate an endocrinological deficiency (i.e., hypothyroidism) following TBI [1], which may cause abnormalities in cell-mediated immunity and thus a posttraumatic immunodeficiency [21, 34, 35, 38]. On the other hand, low T₃ serum concentrations in conjunction with elevated IL-10 and TGF- β levels [19, 21] may also be part of an anti-inflammatory reaction to TBI, preventing uncontrolled inflammatory tissue damage [39].

We could not detect any statistical correlation supporting a causative role of cytokines for the development of the low T₃ syndrome. Cytokine release within the CNS as well as in the periphery is now an accepted component of the pathophysiology of TBI with IL-6 playing a particularly important role [40]. Experimental investigations and clinical studies demonstrated an interrelation between cytokines such as IL-1, IL-6, or TNF and the low T₃ syndrome [4, 5, 8, 9, 16]. Recently, such a role of cytokines in the pathogenesis of low T₃ syndrome has been challenged. At least the early phase of low T₃ syndrome seemed not to be caused by IL-6, since changes in thyroid hormones preceded increased cytokine levels in surgical patients [41]. Moreover, endotoxin-induced low T₃ syndrome was not attenuated when IL-1, IL-6, or TNF were neutralized [6, 10, 11]. However, in these studies cytokine activity was blocked by systemic administration of inhibitors, which may not cross the blood-brain barrier in a sufficient manner (e.g., antibodies), and thus, immune mediators may promote the low T₃ syndrome at a central level. Since IL-6 receptor and the signal-transducing molecule gp130 are localized in the CNS, particularly in the hypothalamus, and since IL-6 synthesis is upregulated in the brain after TBI [42–45], it seemed reasonable to investigate a putative influence of this cytokine released into CSF on thyroid hormone metabolism. However, our data did not support this hypothesis. Therefore, it may well be that the release of IL-6 and TNF, and the low serum T₃ levels are simultaneous but independent consequences of the acute-phase reaction after TBI, and that a particular, still unknown component of this response may be involved in the pathogenesis of the low T₃ syndrome, as suggested previously [7, 9, 20]. A relationship between IL-10 levels and low T₃ syndrome was also absent in another clinical study [12]. The lack of such correlations may also be due to an independent pathophysiology of low T₃ syndrome occurring after TBI, since some authors described unchanged values of reverse T₃ [17]. However, several other reports found increased concentrations of reverse T₃ suggesting altered

hepatic thyroxin deiodinase type 1 activity similar to other patient groups [13, 15, 18]. Additionally, it cannot be ruled out that statistical significance (especially if the effects to be expected are moderate [7]) was missed due to a limited number of investigated subjects in this special group of patients. Additional mechanisms may also lead to low T₃ syndrome following TBI. Fasting and starvation cause a prompt decline in serum T₃ and FT₃ [1], and are relevant, since malnutrition as well as hypercatabolism are common findings after severe TBI [46]. In a similar group of head-injured patients, treated according to an identical therapy regimen on our intensive care unit [28] during the same study period, an initial temporary hypercatabolism was found. Despite early enteral feeding, positive or neutral nitrogen balance could not be achieved in these patients (unpublished results, personal communication Professor R. Stocker). TBI induces an increase in serum levels of epinephrine, norepinephrine, and dopamine which are suggested to play a role in causing low T₃ syndrome and which may also influence cytokine levels [17, 47–49]. Thus, in this study a disturbed nutritional state and the sympathoadrenal response may both induce or aggravate a low T₃ syndrome in the patients. Therapeutic administration of dopamine requires a special consideration, since thyroid-stimulating hormone (TSH) levels are suppressed during infusion [50, 51]. This was also shown in brain-injured patients [13]. The situation is different for T₃ and T₄. In fact, some authors did not detect a significant decrease of these hormones after initiation of dopamine infusion [13, 50], whereas others have shown a decrease of T₄ during a newly appearing period of shock requiring additional dopamine treatment [51]. Thus, routine administration might confound our results. However, since all patients received the same low dose during the respective study period, we regard the impact on the results as of minor effect, representing a mild but inevitable bias.

The severity of thyroid hormonal disturbance was not predictive of the clinical outcome in severely brain-injured patients, which is contrary to a previous study [17], but is supported by others [13, 15]. However, in an older study, reduction of T₄ was proportional to the severity of coma [14]. This might be reflected by our finding that patients with a low T₃-low T₄ status had to be treated longer in the intensive care unit as compared to those with low T₃ alone. Regarding the putative effects of low T₃ syndrome on the damaged brain, it has been shown that tissue T₃ concentrations in cerebral cortex were significantly lower in a group of low T₃ syndrome patients compared with those in control patients [52]. A global reduction of

cerebral blood flow as well as of cerebral glucose metabolism was induced by hypothyroidism of short duration [53]. It might be hypothesized that a reduction in serum T₃ (and T₄) reduces metabolic demands in the brain following injury, which may be a beneficial effect, comparable to the pharmacological concept underlying therapeutic barbiturate coma in TBI patients. On the other hand, since this effect is partly explained by an increased vascular resistance and might also result from an insufficient extraction of oxygen and glucose from the blood [53], these findings could as well represent an inadequate fulfillment of neuronal metabolic requirements. Furthermore, hypothyroidism is known to affect oligodendroglial and neuronal proliferation, apoptosis, migration, and differentiation [54, 55]. Thus, the low T₃ syndrome may negatively influence cerebral recovery after TBI also at that cellular level. Since there is an ongoing debate on the functional effects of the syndrome at a cellular level as well as on its systemic consequences (beneficial adaptation vs. maladaptation), proof for any of these hypotheses is lacking to date. Concerning therapeutic thyroid hormone replacement, it has been stated that there is no clear evidence that T₃ or T₄ treatment of the low T₃ syndrome is disadvantageous, but there is also no certain proof that it is beneficial [1, 2].

Conclusion

Our data show a statistical association between the suppression/recovery of cellular host defense markers and the severity of the low T₃ syndrome after TBI. By contrast, a correlation of cytokine levels with the low T₃ syndrome after TBI was not found in this study. Experimental studies are warranted to further elucidate this possible interrelation at a functional level.

Acknowledgments

The authors wish to express their gratitude to Ms. E. Ammann for expert technical assistance. We thank the medical and nursing staff of the intensive care unit at the Division of Trauma Surgery, University Hospital Zurich, for sustained inspiration and support. Supported by grants from the Swiss National Science Foundation (31-36375.92 and 31-42490.94).

References

1. De Groot LJ. Dangerous dogmas in medicine: the nonthyroidal illness syndrome. *J Clin Endocrinol Metab* 1999;84:151–64.
2. Docter R, Krenning EP, de Jong M, et al. The sick euthyroid syndrome: changes in thyroid hormone serum parameters and hormone metabolism. *Clin Endocrinol (Oxf)* 1993;39:499–518.
3. Wartofsky L, Burman KD, Ringel MD. Trading one “dangerous dogma” for another? Thyroid hormone treatment of the “euthyroid sick syndrome”. *J Clin Endocrinol Metab* 1999;84:1759–60.

4. Bartalena L, Bogazzi F, Brogioni S, et al. Role of cytokines in the pathogenesis of the euthyroid sick syndrome. *Eur J Endocrinol* 1998;138:603–14.
5. Boelen A, Platvoet-Ter Schiphorst MC, Wiersinga WM. Soluble cytokine receptors and the low 3,5,3'-triiodothyronine syndrome in patients with nonthyroidal disease. *J Clin Endocrinol Metab* 1995;80:971–6.
6. Boelen A, Platvoet-Ter Schiphorst MC, Wiersinga WM. Immunoneutralization of interleukin-1, tumor necrosis factor, interleukin-6 or interferon does not prevent the LPS-induced sick euthyroid syndrome in mice. *J Endocrinol* 1997;153:115–22.
7. Boelen A, Platvoet-Ter Schiphorst MC, Wiersinga WM. Association between serum interleukin-6 and serum 3,5,3'-triiodothyronine in nonthyroidal illness. *J Clin Endocrinol Metab* 1993;77:1695–9.
8. Davies PH, Black EG, Sheppard MC, et al. Relation between serum interleukin-6 and thyroid hormone concentrations in 270 hospital in-patients with non-thyroidal illness. *Clin Endocrinol (Oxf)* 1996;44:199–205.
9. Hashimoto H, Igarashi N, Yachie A, et al. The relationship between serum levels of interleukin-6 and thyroid hormone in children with acute respiratory infection. *J Clin Endocrinol Metab* 1994;78:288–91.
10. Van der Poll T, Endert E, Coyle SM, et al. Neutralization of TNF does not influence endotoxin-induced changes in thyroid hormone metabolism in humans. *Am J Physiol* 1999;276:R357–62.
11. Van der Poll T, Van Zee KJ, Endert E, et al. Interleukin-1 receptor blockade does not affect endotoxin-induced changes in plasma thyroid hormone and thyrotropin concentrations in man. *J Clin Endocrinol Metab* 1995;80:1341–6.
12. Boelen A, Schiphorst MC, Wiersinga WM. Relationship between serum 3,5,3'-triiodothyronine and serum interleukin-8, interleukin-10 or interferon gamma in patients with nonthyroidal illness. *J Endocrinol Invest* 1996;19:480–3.
13. Chiolerio RL, Lemarchand-Beraud T, Schutz Y, et al. Thyroid function in severely traumatized patients with or without head injury. *Acta Endocrinol (Copenh)* 1988;117:80–6.
14. Fleischer AS, Rudman DR, Payne NS, et al. Hypothalamic hypothyroidism and hypogonadism in prolonged traumatic coma. *J Neurosurg* 1978;49:650–7.
15. Hackl JM, Gottardis M, Wieser C, et al. Endocrine abnormalities in severe traumatic brain injury – a cue to prognosis in severe craniocerebral trauma? *Intensive Care Med* 1991;17:25–9.
16. Tenedieva VD, Potapov AA, Gaitor EI, et al. Thyroid hormones in comatose patients with traumatic brain injury. *Acta Neurochir Suppl (Wien)* 2000;76:385–91.
17. Woolf PD, Lee LA, Hamill RW, et al. Thyroid test abnormalities in traumatic brain injury: correlation with neurologic impairment and sympathetic nervous system activation. *Am J Med* 1988;84:201–8.
18. Ziegler MG, Morrissey EC, Marshall LF. Catecholamine and thyroid hormones in traumatic injury. *Crit Care Med* 1990;18:253–8.
19. Csuka E, Morganti-Kossmann MC, Lenzlinger PM, et al. IL-10 levels in cerebrospinal fluid and serum of patients with severe traumatic brain injury: relationship to IL-6, TNF-alpha, TGF-beta1 and blood-brain barrier function. *J Neuroimmunol* 1999;101:211–21.
20. Kossmann T, Hans VH, Imhof HG, et al. Intrathecal and serum interleukin-6 and the acute-phase response in patients with severe traumatic brain injuries. *Shock* 1995;4:311–7.
21. Morganti-Kossmann MC, Hans VH, Lenzlinger PM, et al. TGF-beta is elevated in the CSF of patients with severe traumatic brain injuries and parallels blood-brain barrier function. *J Neurotrauma* 1999;16:617–28.
22. Rubin LA, Nelson DL. The soluble interleukin-2 receptor: biology, function, and clinical application. *Ann Intern Med* 1990;113:619–27.
23. Koukkou E, Panayiotidis P, Alevizou-Terzaki V, et al. High levels of serum soluble interleukin-2 receptors in hyperthyroid patients: correlation with serum thyroid hormones and independence from the etiology of the hyperthyroidism. *J Clin Endocrinol Metab* 1991;73:771–6.
24. Mariotti S, Caturegli P, Barbesino G, et al. Thyroid function and thyroid autoimmunity independently modulate serum concentration of soluble interleukin 2 (IL-2) receptor (sIL-2R) in thyroid diseases. *Clin Endocrinol (Oxf)* 1992;37:415–22.
25. Hamerlinck FF. Neopterin: a review. *Exp Dermatol* 1999;8:167–76.
26. Bethea M, Forman DT. Beta 2-microglobulin: its significance and clinical usefulness. *Ann Clin Lab Sci* 1990;20:163–8.
27. Bjerrum OW, Nissen MH, Borregaard N. Neutrophil beta-2 microglobulin: an inflammatory mediator. *Scand J Immunol* 1990;32:233–42.
28. Stocker R, Bernays R, Kossmann T, et al. Monitoring and treatment of acute head injury. *Update Intensive Care Emerg Med* 1995;22:196–219.
29. Teasdale G, Jennett B. Assessment of coma and impaired consciousness. A practical scale. *Lancet* 1974;2:81–4.
30. Marshall LF, Marshall SB, Klauber MR, et al. A new classification of head injury based on computerized tomography. *J Neurosurg* 1991;75:Suppl:S14–20.
31. Jennett B, Bond M. Assessment of outcome after severe brain damage. *Lancet* 1975;1:480–4.
32. Lenzlinger PM, Hans VH, Joller-Jemelka HI, et al. Markers for cell-mediated immune response are elevated in cerebrospinal fluid and serum after severe traumatic brain injury in humans. *J Neurotrauma* 2001;18:479–89.
33. Matthews JN, Altman DG, Campbell MJ, et al. Analysis of serial measurements in medical research. *Br Med J* 1990;300:230–5.
34. Hoyt DB, Ozkan AN, Hansbrough JF, et al. Head injury: an immunologic deficit in T-cell activation. *J Trauma* 1990;30:759–66.
35. Quattrocchi KB, Issel BW, Miller CH, et al. Impairment of helper T-cell function following severe head injury. *J Neurotrauma* 1992;9:1–9.
36. Innerhofer P, Tilz G, Fuchs D, et al. Immunologic changes after transfusion of autologous or allogeneic buffy coat-poor versus WBC-reduced blood transfusions in patients undergoing arthroplasty. II. Activation of T cells, macrophages, and cell-mediated lympholysis. *Transfusion* 2000;40:821–7.
37. Villa-Verde DM, de Mello-Coelho V, Farias-De-Oliveira DA, et al. Pleiotropic influence of triiodothyronine on thymus physiology. *Endocrinology* 1993;133:867–75.
38. Mocchegiani E, Imberti R, Testasecca D, et al. Thyroid and thymic endocrine function and survival in severely traumatized patients with or without head injury. *Intensive Care Med* 1995;21:334–41.
39. Shirin H, Dotan I, Papa M, et al. Inhibition of concanavalin A-induced acute T cell dependent hepatic damage in mice by hypothyroidism. *Liver* 1999;19:206–11.
40. Morganti-Kossmann MC, Rancan M, Otto VI, et al. Role of cerebral inflammation after traumatic brain injury: a revisited concept. *Shock* 2001;16:165–77.
41. Wellby ML, Kennedy JA, Barreau PB, et al. Endocrine and cytokine changes during elective surgery. *J Clin Pathol* 1994;47:1049–51.
42. Hans VH, Kossmann T, Joller H, et al. Interleukin-6 and its soluble receptor in serum and cerebrospinal fluid after cerebral trauma. *Neuroreport* 1999;10:409–12.
43. Hans VH, Kossmann T, Lenzlinger PM, et al. Experimental axonal injury triggers interleukin-6 mRNA, protein synthesis and release into cerebrospinal fluid. *J Cereb Blood Flow Metab* 1999;19:184–94.
44. Jones TH. Interleukin-6, an endocrine cytokine. *Clin Endocrinol (Oxf)* 1994;40:703–13.

45. Vallieres L, Rivest S. Regulation of the genes encoding interleukin-6, its receptor, and gp130 in the rat brain in response to the immune activator lipopolysaccharide and the proinflammatory cytokine interleukin-1beta. *J Neurochem* 1997;69:1668–83.
46. Young B, Ott L. (1996). Nutritional and metabolic management of the head-injured patient. In: Narayan RK, Wilberger JE, Povlishock JT, eds. *Neurotrauma*. New York: McGraw-Hill:345–63.
47. Chiolerio R, Berger M. Endocrine response to brain injury. *New Horiz* 1994;2:432–42.
48. Heesen M, Deinsberger W, Dietrich GV, et al. Increase of interleukin-6 plasma levels after elective craniotomy: influence of interleukin-10 and catecholamines. *Acta Neurochir (Wien)* 1996; 138:77–80.
49. Woiciechowsky C, Asadullah K, Nestler D, et al. Sympathetic activation triggers systemic interleukin-10 release in immunodepression induced by brain injury. *Nat Med* 1998;4:808–13.
50. Van den Berghe G, de Zegher F, Lauwers P. Dopamine and the sick euthyroid syndrome in critical illness. *Clin Endocrinol (Oxf)* 1994;41:731–7.
51. Kaptein EM, Spencer CA, Kamel MB, et al. Prolonged dopamine administration and thyroid hormone economy in normal and critically ill subjects. *J Clin Endocrinol Metab* 1980;51:387–93.
52. Arem R, Wiener GJ, Kaplan SG, et al. Reduced tissue thyroid hormone levels in fatal illness. *Metabolism* 1993;42:1102–8.
53. Constant EL, de Volder AG, Ivanoiu A, et al. Cerebral blood flow and glucose metabolism in hypothyroidism: a positron emission tomography study. *J Clin Endocrinol Metab* 2001;86:3864–70.
54. Bernal J, Nunez J. Thyroid hormones and brain development. *Eur J Endocrinol* 1995;133:390–8.
55. Oppenheimer JH, Schwartz HL. Molecular basis of thyroid hormone-dependent brain development. *Endocr Rev* 1997;18:462–75.
56. Jennett B, Teasdale G, Braakman R, et al. (1976). Predicting outcome in individual patients after severe head injury. *Lancet* 1976;1:1031–4.

Address for Correspondence

Philipp M. Lenzlinger, MD
 Department of Surgery
 University Hospital Zurich
 Rämistrasse 100
 8091 Zürich
 Switzerland
 Phone (+41/44) 255-1111, Fax -4406
 e-mail: philipp.lenzlinger@usz.ch